House of Representatives

General Assembly

File No. 379

January Session, 2011

House Bill No. 5429

House of Representatives, April 5, 2011

The Committee on Human Services reported through REP. TERCYAK of the 26th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING THE AVAILABILITY OF MEDICARE SUPPLEMENT INSURANCE TO PERSONS ELIGIBLE FOR THE QUALIFIED MEDICARE BENEFICIARY PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-495 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended (Title I, Part I of P.L. 89-97); "Medicare supplement policy" means any individual health insurance policy delivered or issued for delivery to any resident of the state who is eligible for Medicare, except any long-term care policy as defined in section 38a-501.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any Medicare supplement policy which

has an anticipated loss ratio of less than sixty-five per cent for any individual Medicare supplement policy defined in Section 1882(g) of Title XVIII of the Social Security Act, 42 USC 1395ss(g), as amended. No such company, society or corporation may deliver or issue for delivery any Medicare supplement policy without providing, at the time of solicitation or application for the purchase or sale of such coverage, full and fair disclosure of any coverage supplementing or duplicating Medicare benefits.

(c) Each Medicare supplement policy shall provide coverage for home health aide services for each individual covered under the policy when such services are not paid for by Medicare, provided (1) such services are provided by a certified home health aide employed by a home health care agency licensed pursuant to sections 19a-490 to 19a-503, inclusive, and (2) the individual's physician has certified, in writing, that such services are medically necessary. The policy shall not be required to provide benefits in excess of five hundred dollars per year for such services. No deductible or coinsurance provisions may be applicable to such benefits. If two or more Medicare supplement policies are issued to the same individual by the same insurer, such coverage for home health aide services shall be included in only one such policy. Notwithstanding the provisions of subsection **[**(g)**]** (h) of this section, the provisions of this subsection shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1986.

(d) Whenever a Medicare supplement policy provides coverage for the cost of prescription drugs prescribed after the hospitalization of the insured, outpatient surgical procedures performed on the insured in any licensed hospital shall constitute "hospitalization" for purposes of such prescription drug coverage in such policy.

(e) Notwithstanding the provisions of subsection **[**(g)**]** (h) of this section, each Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1988, shall provide benefits, to any woman covered under the policy, for

mammographic examinations every year, or more frequently if recommended by the woman's physician, when such examinations are not paid for by Medicare.

(f) A Qualified Medicare Beneficiary may purchase a Medicare supplement policy or change Medicare supplement policy plans, as permitted by federal law.

[(f)**]** (g) The Insurance Commissioner shall adopt such regulations as he deems necessary in accordance with chapter 54 to carry out the purposes of this section.

[(g)**]** (h) The provisions of this section shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1987, and prior to the effective date of any regulations adopted pursuant to section 38a-495a.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-495

HS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 $	FY 13 $
Department of Social Services	GF - Savings	Potential Minimal	Potential Minimal

Note: GF=General Fund

Municipal Impact: None

Explanation

This bill could result in a Medicaid savings to the state associated with reduced payments for Qualified Medicare Beneficiaries (QMBs).

Currently, the state Medicaid program pays premiums, co-payments and deductibles for all QMBs who do not have supplemental policies. Should a Medicaid client, who currently pays no out of pocket expenses for the QMB program, choose to pay for a new Medicare supplemental policy, the state could realize co-payment and deductible savings. However, it is anticipated that there would be few such clients who would choose to increase their out of pocket expenditures.

Medicaid currently pays $157 million in Medicare costs for 100,000 QMBs, or an average of $1,570 per person, per year.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

HB 5429

AN ACT CONCERNING THE AVAILABILITY OF MEDICARE SUPPLEMENT INSURANCE TO PERSONS ELIGIBLE FOR THE QUALIFIED MEDICARE BENEFICIARY PROGRAM.

SUMMARY:

This bill allows qualified Medicare beneficiaries (QMBs) to purchase Medicare supplement policies or change existing policies, to the extent federal law allows. Federal law appears to prohibit this (see COMMENT).

Under the QMB program, the state's Medicaid program pays the Medicare beneficiaries' Part A and B premiums and certain other cost sharing as a way to reduce the likelihood that these individuals will require full Medicaid coverage. The state pays the cost sharing and the federal government reimburses it for half of these expenditures. The state pays only when the beneficiary's medical provider accepts both Medicare and Medicaid.

EFFECTIVE DATE: Upon passage

BACKGROUND

QMBs

The state's Medicaid program pays certain Medicare cost sharing under an umbrella Medicare Savings Program (MSP). MSP consists of the QMB, Specified Low-Income Medicare Beneficiary, and Qualified Individual programs. The state pays Medicare cost sharing (Part A and B deductibles and premiums) for QMBs and receives a 50% federal match for doing so.

Before 2009, the QMB program was limited to people with income under the federal poverty level (FPL) and $4,000 in assets (singles). PA

09-2 and PA 09-5, September Special Session, raised the income limit to over 200% of the FPL and eliminated the asset test. This enabled many more individuals to qualify for the program. And since individuals in the MSP program are automatically eligible for the Medicare Part D Low-Income Subsidy program, the result in Connecticut has been that a substantially smaller number of residents are receiving ConnPACE's wrap-around benefit.

COMMENT

Federal Prohibition

Federal law appears to prohibit a person from selling or issuing a supplement policy to an individual entitled to Medicare Part A or enrolled in Medicare Part B unless that person obtains from the applicant a statement that he or she is entitled to Medicaid (fully or partially). Further, the law says that if the statement indicates that the person is eligible for Medicaid, the sale of a supplement is considered a violation (and hence subject to penalty) unless the statement indicates that the only Medicaid assistance the individual is entitled to is help with the payment of premiums (42 USC § 1395ss(d)(3)(B)(iii)(III)). Connecticut's QMB program also pays other Medicare cost sharing (e.g., deductibles), hence the federal prohibition would seem to apply.

COMMITTEE ACTION

Human Services Committee

Joint Favorable
Yea 17 Nay 0 (03/17/2011)